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The Medicare Discount Drug Card: States Get Ready to Make it Work

As states prepare to accept the latest "gift horse" from the federal government, they're looking it straight in the mouth. The "gift" is the Medicare discount drug card program that will soon be available to Medicare beneficiaries. Part of the Medicare reform law passed in 2003, the drug cards are an interim measure designed to give beneficiaries some relief from high drug costs until the much broader Medicare Part D drug benefit goes into effect in January 2006.

Private entities (mostly insurers and pharmacy benefit managers) are sponsoring the cards, which are expected to provide discounts of 10 to 15 percent, or even 25 percent, depending on the drug.

The program is divided into two tiers, depending on beneficiary income. Those with incomes below 135 percent of the federal poverty level ($12,123 for an individual, $16,362 for couples) will pay no enrollment fee and will get a credit on their cards from the federal government totaling $1,200 — $600 toward their drug expenses in 2004 and $600 in 2005. The U.S. Department of Health and Human Services (HHS) estimates that more than 7 million low-income beneficiaries will qualify for the credits, which could cost the federal government some $9 billion over 2004 and 2005.

Beneficiaries whose incomes are above 135 percent of the federal poverty level get no federal subsidy, and they may be charged an annual enrollment fee of up to $30 for a discount card (although HHS estimates that one-fourth of card sponsors will waive the enrollment fee).

MUCH TO DO

State officials are pleased that the federal government is finally stepping forward with subsidies that will cover some of the drug expenses of the poor. But what states do with those subsidies -- and with the drug card program in general -- will vary widely, depending, among other things, on what drug assistance programs the state already has in place.

Currently, 30 states have laws authorizing pharmacy assistance programs for low-income seniors and the disabled. In these programs (22 of which are operating), states use their own funds to subsidize a portion of the cost of prescriptions. Another 20 states have created or authorized programs that offer a discount card (but no subsidy) to low-income persons; a majority of these states also have a separate subsidy program.

Finally, five states have obtained 1115 "pharmacy plus" waivers from HHS that have enabled them to expand the number of people who are eligible for prescription drug assistance under Medicaid. These states benefit from the federal match for Medicaid, but it's not expected that they'll be able to take advantage of the $600 credits. Under the law, the 7 million "dual eligibles" who get drug coverage through Medicaid are not eligible for the new benefit.

States that haven't created a pharmacy assistance program will have to do relatively little to prepare for the Medicare card. Those states that only endorse and help to publicize discount cards may not have a great deal to do either -- low-income beneficiaries should be able to sign up for both the state- and the federal-endorsed cards. But the 22 states that have pharmacy subsidy programs -- and that want to substitute federal funds for state funds where possible, and to coordinate benefits between the two programs -- have a mountain of work ahead of them.

And they don't have much time. Beneficiaries will start signing up for the cards in May, and the cards become effective in June.

[Medicare Rx Cards, p.5]

IN THIS ISSUE

State Health Notes is supported in part by a grant from the Robert Wood Johnson Foundation.

PRIMARY CARE *NEWS*

The ABCs of Improving Child Development

The first few years of a child's life create an everlasting imprint for future success and well-being. Research shows that 15 to 17 percent of American children have a developmental or behavioral disorder such as a delay in speech and language development, mental retardation, learning disabilities, and emotional and behavioral problems. Among low-income children, the percentage with such disorders is as high as one-third.

Left untreated, these disorders can lead to delinquency, failure to graduate from high school, teen pregnancy, and the inability to maintain employment or to live independently.

Early intervention – before kindergarten – has been shown to dramatically improve children's developmental outcomes and to prevent the need for more intensive and expensive care at a later age. Yet, the National Academy for State Health Policy (NASHP) reports that only half the children with such behavioral and development disorders are identified before they enter school.

In an effort to improve children's developmental outcomes, the Commonwealth Fund launched an initiative in 1999 called "Assuring Better Child Health and Development" or "ABCD I." Administered by NASHP, the program worked to strengthen the capacity of the health-care system to deliver child development services for low-income children through Medicaid, SCHIP and community health centers. The program focused on the full range of children's healthy development, including physical, cognitive and emotional.

The next phase – "ABCD II" – will focus solely on social and emotional advancement. Research documents that social/emotional aspects of development are as important as physical and cognitive development. Children who are viewed as "sad, mad or bad" are far less likely to experience school success, less likely to respond to preschool intervention programs and more likely to require serious help in later years.

Five states – California, Illinois, Iowa, Minnesota and Utah – were selected to participate in "ABCD II," which began in January 2004 and will to run for three years. Each state received approximately $55,000 to develop and test strategies to improve the delivery and financing of early mental health development services to children under five through their Medicaid programs.

In addition to evaluating components of the initiative, states will "take the lessons they learn throughout the process and disseminate the information to other states" – both those participating in the initiative, as well as those interested in duplicating their efforts, said Neva Kaye, program director with NASHP.

MAKING THE BEST OF MEDICAID

Families with children with social/emotional difficulties may recognize that they need help, but they often face a number of barriers to care. First, national data indicates that only 50 percent of children with psychosocial problems are screened by their primary-care providers, and an even smaller number receive appropriate treatment. Pediatricians are not adequately trained to identify social/emotional problems and also are "reluctant to attach stigmatizing labels to very young children," Kaye explained.

In addition, the fragmented nature of services for children with social and emotional problems represents an enormous barrier to care. Effective interventions usually require the involvement of more than one provider or system of care, which "creates opportunities for children to be lost in the shuffle," said Kaye.

Medicaid, however, can play an important role in identifying children in need, as well as providing a tool to finance services that promote healthy social/emotional development. Through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) component of Medicaid, states have a "clear avenue" to identify children in need and to finance specific services to assure healthy mental development, explained Kaye.

And, as Medicaid serves nearly half of U.S. infants and an estimated one-in-three children under the age of six — whose low-income status put them at an even greater risk for delayed social and emotional development — the program is in a "unique position" to promote children's healthy mental development, says a September 2003 NASHP report.

UTAH: TOWARD SUCCESS

To date, Utah has been the only state to progress from "ABCD I" to "ABCD II." Utah is building on what it accomplished during the first segment of the initiative.

To improve the odds of healthy mental development of Medicaid children, Utah plans to: 1) increase screening for infant mental health as part of EPSTD/well-child visits; 2) increase the interactions among Medicaid providers to ensure that they direct children and their families to appropriate services; 3) increase screening within pediatric practices for maternal depression to 60 days postpartum; and 4) increase the capacity of the mental health system to serve infants.

The last objective focuses on what the health-care system does after children in need are identified. "If the referral and treatment mechanisms aren't in place, the best screening tools will be useless," said Kaye. And, while most states plan to test the effectiveness and usability of screening tools, the bulk of their efforts will "focus on the provision and coordination of service delivery after high-risk children are identified."

Utah Medicaid plans to use "learning collaboratives" throughout the initiative. The collaboratives, comprising policymakers, pediatricians and mental health experts, will evaluate the effectiveness of screening tools, improve developmental screening practices among Medicaid providers, share information about screening tools and new screening policies, and disseminate information on treatment practices and referral models to providers.

"States don't have to reinvent the wheel to accomplish the goals of this initiative," said Kaye. Nor do they have to spend additional monies. For example, strategies employed by states participating in "ABCD I" that required little or no additional spending include: promoting the use of age- specific screening and diagnostic tools, clearly delineating the responsibilities of various providers in ensuring children's healthy mental development, creating educational materials for parents, adopting new billing and reimbursement policies to facilitate the provision of developmental services, and establishing interagency collaboration and billing systems.

Most states recognize the importance of healthy pediatric mental development and are "very dedicated" to this issue, noted Kaye. In many cases, they are "already doing what they need to, it's just a matter of improving coordination across agencies and increasing efficiency among existing resources." *+ACS*

For more , call NASHP at (207) 874-6524, or visit their website at http://www.nashp.org/

HIGHLIGHTS

PRIMARY CARE

Indigent Care Program to End

A 65-year-old South Carolina program that helps indigent cancer patients receive treatment will end in June because hospitals can no longer afford to participate. While the state provided $800,000 for care in 2001, hospitals provided more than $5 million in services the same year, said Alan Waln, coordinator of the South Carolina Cancer Alliance in a March 15 *Columbia State* article. Program administrators explained that the funding, which has remained fixed since 1978, is not sufficient to cover the number of patients treated under the program. Providers, including the five clinics participating in the program, will treat patients until July 1. Patient care advocates say they'll push to expand Medicaid coverage through a waiver to include adults with cancer.

CHILDREN'S HEALTH

Dental Care for Immigrant Kids

Minnesota just launched *Bright Smiles*, a program designed to help Latino and Hmong parents gain access to dental care for their kids. With the help of $100,000 from the United Way, officials hope to reach 1,600 to 2,000 families over the next year. Bilingual staff will educate families about the importance of oral hygiene, distribute informational materials, check children's teeth, hand out toothpaste and brushes, and make referrals to one of two clinics in St. Paul if cleaning is needed. According to the 2000 Surgeon General's report, tooth decay is a common chronic childhood disease affecting up to 50 percent of first graders. For more information about *Bright Smiles*, call (651) 224-2066.

PUBLIC HEALTH

Smoking Speeds Decline

Smoking accelerates cognitive decline in the non-demented elderly, according to new research from the Erasmus Medical Center in Rotterdam, the Netherlands. The researchers found that the rate of cognitive decline in smokers is five times higher than among non-smokers, the *BBC* reported. But smokers who quit significantly slowed the drop in mental abilities. Study author Alewjin Ott conducted a mini-mental-state exam (which measures cognitive function) on 9,209 men and women aged 65 and older. They found that MMSE scores dropped .16 points per year for smokers. For those who recently quit, the MMSE dropped .06 points a year, while those who never smoked had a .03 point annual MMSE decline. The research (published in the March 23 issue of *Neurology*) shows that the longer a person smokes and the more cigarettes they smoke, the faster the cognitive decline. The study contradicts earlier research that found nicotine may protect against Alzheimer's disease.

A Myth Exposed

Many smokers say that smoking provides relief from stress. But researchers at Dundee University in Scotland have found that indulging does just the opposite. According to an article in the March 14 *Scotsman*, the researchers found smoking inhibits the transmission of serotonin, the body's natural stress-relieving hormone. As smokers become deficient in serotonin, they suffer higher levels of stress. The nicotine in the cigarettes provides temporary relief by increasing levels of dopamine, the precursor to seretonin, in the brain, but that effect is only temporary. Smokers need the nicotine to achieve relief from the stress caused by the smoking itself.

Smoke-Free Zone

Citing concerns about health, safety and pollution, Santa Monica became the third city in California to ban smoking in an open public place. City Council members gave initial approval to an ordinance that would ban smoking on most of the 95-year-old pier as well as the four-mile stretch of beach along the city. The bill is expected to pass upon a second reading on April 13. Santa Monica was the first city to enforce a state-mandated ban on smoking in bars, in January 1999. In addition to restricting smoking on the pier and beach, the new ordinance will prohibit lighting up at bus stops within 20 feet of the doorways of government buildings. Violators would face a $250 fine. "This is not about sending armies of cops up and down the beach to haul smokers away," said ordinance supporter and Los Angeles City Council member Jack Weiss, in a March 25 *New York Times* article. "It's about changing attitudes about where it is socially acceptable to smoke." (For more on public smoking bans, see *SHN* #373, 6/3/02)

ORAL HEALTH

Inadequate Payments

Medicaid payments to Maryland dentists are far below the going rate, says a March 24 report from the American Dental Association. The poor reimbursement rates for the 15 most common dental procedures reflects a national trend that has resulted in inadequate dental care for millions of low-income children. The report praised seven states — Delaware, Alabama, Georgia, Indiana, Michigan, South Carolina and Tennessee — for setting up systems in which 75 percent of dentists get reimbursed what they usually charge, a standard that every state should meet, says the ADA. In comparison, no more than 9 percent of Maryland dentists are reimbursed at the rate that dentists in the South Atlantic region usually charge their patients for the 15 procedures. To improve the health of low-income children, Medicaid programs need to consider increasing reimbursement rates for dental procedures, recommends the report.

BEHAVIORAL HEALTH

Terrorism and Addiction

New Yorkers drank more and smoked more after the 9/11 terrorist attacks – and many continued doing so six months after the violence. Researchers from the New York Academy of Medicine randomly telephoned subjects who lived close to the site of the Twin Towers, near Manhattan's southern tip. They found that in October 2001, almost 31 percent of the 988 people surveyed had increased their use of cigarettes, alcohol or marijuana. Six months later, in March 2002, 27 percent of the 854 people surveyed said they were smoking and drinking more than before the terrorists struck. The researchers, who published their findings in the February 2004 *American Journal of Public Health*, theorize that some residents who initially turned to

smoking and drinking to cope with stress may have developed addictions even as their stress declined. A previous survey by the Academy showed that post-traumatic stress disorder actually declined in Manhattan six months after Sept. 11. "These sustained increases in substance use following the Sept. 11 terrorist attacks suggest potential long-term health consequences as a result of the disasters," wrote lead author David Vlahov and colleagues.

HEALTH INSURANCE

Support for Employer Mandates

About half of working-age Americans think that all employers should be required to offer health insurance to all employees, according to a new randomized survey of 1,479 adults. One-quarter opted for a less inclusive mandate, saying employers should have to cover only permanent and full-time employees. Only 10 percent of adults thought that employers should not be required to provide coverage, according to the survey in the March 17 issue of *Health Affairs*. In general, groups that are traditionally more likely to be disenfranchised within the health-care system – including people with lower incomes and less education, as well as Latinos and African-Americans – were most likely to support a "full" mandate on both employers and employees. Previous polls have found that support for mandates drops after respondents are briefed on arguments for and against the laws. The current level of support for mandated coverage may "reflect increasing anxiety among Americans as they observe – and experience – the effects of increasing medical care costs. If so, support for mandated coverage may continue unless alternative solutions address underlying concerns," the authors wrote in the study, "*Workers' Perspectives on Mandated Employer Health Insurance*."

HIV/AIDS

ADAP Funding

States and territories have just received FY 2004 funding for their AIDS drug assistance programs (ADAPs). Part of the Ryan White CARE Act, the $728 million will be used to purchase antiretroviral medications and support services for low-income, uninsured and underinsured HIV-positive individuals. "Today's grants will extend the availability of needed medications to even more people living with HIV/AIDS," said Elizabeth Duke, administrator of the U.S. Department of Health and Human Services' (HHS) Health Resources and Services Administration. But Marsha Martin, executive director of the advocacy group AIDS Action, calls the $728 million "woefully inadequate" to treat all the individuals living with HIV. HHS has itself estimated that there are a half a million people who are HIV positive and either know it or don't, Martin said. "Increasingly, people are living longer with HIV," she said. "And as that happens, we need more access to care." Some of the AIDS advocacy groups say a more appropriate amount would be "approaching" $1 billion, Martin said. According to the National Alliance of State and Territorial AIDS Directors, as of January, 15 states had restricted access to ADAP-funded treatment, including establishing waiting lists of nearly 800 people in ten states. HHS has strongly encouraged Americans to learn their HIV status, and through technologies such as the rapid HIV test, a growing number of people are being tested. Many of the new HIV cases are people who are disproportionately uninsured and low-income. An average of 650 new clients seek out ADAP services each month, and the cost of combination therapy per person per year is about $13,000. That's expensive, activists say, but it's less than the cost of providing people with HIV with emergency department services, hospitalization, rehabilitation and other social services.

ORGAN DONATIONS

Live Donors Face Risks

Galvanized by several recent, highly publicized cases in which living donors died, the Joint Commission on Accreditation of Healthcare Organizations has launched a campaign to educate the public about the risks of donating an organ while alive. Living donors are an increasingly important source of organs for the 82,000 people awaiting transplants, JCAHO President Dennis O'Leary, M.D., said in a press release. Each year, more than 6,000 people donate an organ to a family member or friend. But some donors have revealed that they didn't know what the surgery entailed or the short- and long-term risks to which they would be exposed. So the JCAHO is urging donors to educate themselves and to "speak up" about their concerns before any surgery takes place. Each year, 6,000 people die while awaiting transplantation, and that number is expected to grow, due to the epidemics of morbid obesity, hypertension, diabetes and infectious diseases such as hepatitis C. Only about half the families of potential organ donors consent to donation. Copies of the JCAHO's "Speak Up" brochure are available by calling (877) 223-6866.

PRESCRIPTION DRUGS

More Pressure on the Drug Co.'s

Minnesota Gov. Tim Pawlenty has opened up another front in his battle to lower prescription drug prices. After Minnesota established a website to help state residents reimport prescription drugs from state-inspected pharmacies in Canada (*SHN*, 412, 1/26/04) drug giant Pfizer began limiting drug exports to Canada. Now, at Pawlenty's urging, the Minnesota State Board of Investment (which the governor chairs) is asking pharmaceutical giant Pfizer to stop those actions and to change its pricing structure. The state board oversees $43 billion worth of retirement funds for state employees, retirees, teachers and public employees, including more than $470 million worth of Pfizer stock (about 0.2 percent of total Pfizer shares). The resolution asks Pfizer to: 1) adopt pricing policies that are not sustainable and proportionate; 2) stop intentionally limiting sales of company products to Canadian pharmacies or wholesalers that allow purchase by non-Canadian residents; and 3) fully disclose all costs incurred in maintaining the current pricing structure, including lobbying and promotion costs. The state board plans to ask the same of AstraZeneca, Bayer, Eli Lilly, GlaxoSmithKline, Merck, and Wyeth. "The State of Minnesota is a major shareholder in Pfizer and other drug companies and we have a responsibility to protect that investment," Pawlenty said. The governor also sent letters to his fellow governors, asking them to join him in using shareholder resolutions to pressure drug companies to lower their prices.

An aide to the governor told the *Minneapolis Star Tribune* that Pawlenty believes he can make the case that drug companies will price themselves out of the market and invite heavier regulation if they don't voluntarily lower their prices. The Pfizer resolution won't be considered by shareholders until 2007, but Pawlenty hopes to meet with company officials at their annual meeting in April.

Conference Slate

✦*Cover the Uninsured Week, May 10-16, 2004*, sponsored by the Robert Wood Johnson Foundation, with more than 1,000 events from coast to coast. Campaign staff will work with communities and diverse coalitions to sponsor a broad range of activities including health and enrollment fairs for uninsured Americans and health coverage seminars for small business owners. Elevating the issue on the national and local agendas, educating Americans and providing immediate assistance to the uninsured and small business owners are among the goals for Cover the Uninsured Week. For more, visit http://www.covertheuninsuredweek.org or call (202) 572-2928

✦*Planning, Funding, and Sustaining a Hospital-Based Palliative Care Program*, an Institute hosted by the Center to Advance Palliative Care, May 6-8, Minneapolis, Minnesota. The program will cover the case for hospital-based palliative care programs, funding strategies, quality measures, and hospital-hospice partnerships. Geared toward physicians, nurses and administrators who are responsible for planning and implementing hospital and health system-based palliative care programs. Call the event hotline at (212) 201-2680 or visit http://www.capc.org

✦*Solutions for Success*, May 5-7, Chicago, Illinois. Hosted by the Assisted Living Federation of America, conference topics include financing and marketing strategies, nursing and resident care, advances in Alzheimer's care, and human resources and leadership training . For more information or to register, call (800) 258-7030.

DON'T FORGET!

NCSL's Spring Forum is scheduled for April 29-May1 in Washington, D.C. Topics on the agenda include: jobs and the economy; unfunded mandates; implementing the No Child Left Behind Act; and more. Guest speakers include Mara Liasson, National Political Correspondent for NPR, and the Honorable Jonathan S. Adelstein, Commissioner, Federal Communications Commission. Interested parties can register online at http://www.ncsl.org/forum/, or by calling Barbara Houlik at (303) 364-7700.

Medicare Rx Cards, from p. 1

For many states, the first order of the day may be to help beneficiaries choose among the many Medicare-approved cards that will be available.

HHS approved 30 cards (sponsored by 28 different vendors) that will be available nationwide, with another 19 in limited areas. (In addition, 43 sponsors representing 84 Medicare+Choice plans – now called Medicare Advantage plans – will offer cards to the beneficiaries enrolled in their health plans.)

The cards will vary in terms of the drugs covered, the size of the discounts, and the pharmacies that accept the cards. Card sponsors may change the drugs and the discounts on a weekly basis (although beneficiaries may change their cards only once a year).

The idea is that the market will prove which cards are best -- but state officials are worried that their most vulnerable residents will be beseiged by aggressive marketing from card vendors and won't necessarily pick the best card for their needs. Already, officials say, they're fielding calls from seniors and disabled folks who are worried that they're *losing* their drug benefit, instead of gaining a new one.

"For the low-income, it's fabulous, it's a very generous benefit," said Laurie Hines, executive director of Missouri Senior Rx, Missouri's discount drug program for low-income seniors. "But for those of us who run these programs, for the pharmacists who will have to help beneficiaries choose which card to use, and for the seniors, it's an impending nightmare."

Many officials say they are not recommending that their higher-income beneficiaries apply for the $30 cards. There are simply too many other, less expensive routes to more generous coverage available -- including private card programs and reimportation.

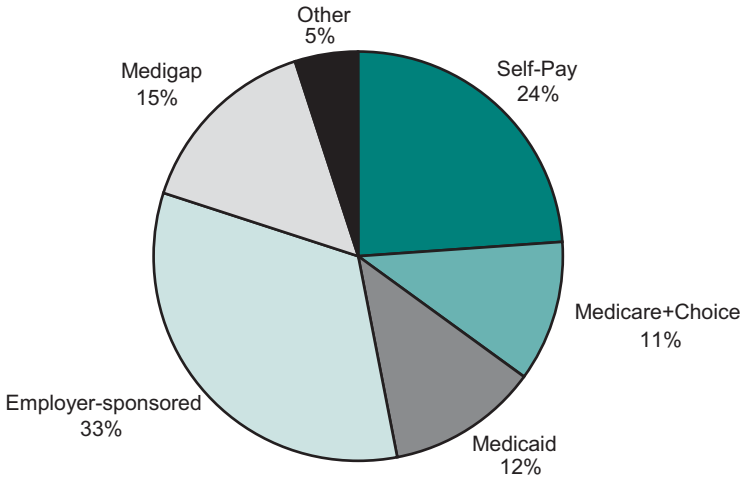
HHS officials downplay the predictions of confusion and point out that beneficiaries will be able to compare the prices of drugs on the various cards by going to www.medicare.gov or by calling 1-800-MEDICARE.

At a press conference, HHS Secretary Tommy Thompson said that Medicare will send out brochures explaining the card program, the Social Security Administration will mail letters to beneficiaries qualifying for the $600/year benefit, and Medicare will follow up with its own letter in an effort to enroll low-income beneficiaries.

MOVING AHEAD

For many states, the two biggest questions are: how can we make the federal benefit wrap around our own program, and how can we ensure that our enrollees get all the federal assistance to which they're entitled (which would reduce state costs)?

Prescription Drug Coverage of Medicare Beneficiaries, 2002



Source: Pacific Research Institute, February 2004

[Medicare Rx Cards, p.6]

Medicare Rx Cards, from p. 5

In New Jersey, officials have decided that the best way to accomplish both those goals is to limit the number of Medicare cards to one.

New Jersey runs some of the biggest and oldest pharmacy assistance programs in the U.S. The Pharmaceutical Assistance to the Aged & Disabled (PAAD) program and Senior Gold are open to low-income seniors and the disabled. PAAD cardholders pay $5 for each covered prescription, and Senior Gold members (who have higher income limits) pay $15 plus 50 percent of the remaining cost for each drug.

The Garden State is among a number of states that have been lobbying HHS to allow them to pick the card program that's best for their beneficiaries and then automatically enroll those beneficiaries into that program, said Kathleen Mason, assistant commissioner for the New Jersey Department of Health and Senior Services.

Automatic enrollment would prevent beneficiaries from having to deal with confusing paperwork, would presumably get them the best deal, and would help prevent individuals from slipping through the cracks by not enrolling at all.

But in order to stimulate market competition, the law says that beneficiaries must have a choice between cards. So New Jersey must instead pick a "preferred" card and help enrollees sign up for that one.

The state plans to scrutinize the cards and select the one that covers the same drugs in the same pharmacies as in the current PAAD program. The state will then send a preprinted enrollment form for the preferred discount card to the 81,000 people who qualify for the $600 credit, for them to sign and return.

In testimony before the state Legislature, Mason cautioned, "We know that all 81,000 people will not return the application. There is no incentive for a beneficiary to enroll since the PAAD plan is more generous than the Medicare benefit."

Nevertheless, the federal program should save the state significant amounts of money. New Jersey figures that of the 190,000 PAAD enrollees, 81,000 will qualify for the $600 credit. If all those beneficiaries use the federal credits before they use their PAAD benefits, the state could avoid about $90 million in costs.

The state also has determined how PAAD can be coordinated with the federal program. Medicare requires that persons qualifying for the $600 credit pay 10 percent of the cost of each prescription, or 5 percent if their 2003 income was below $8,980 (single) or $12,120 (couple). The rest of the prescription cost will be deducted from the federal credit until it is used up. PAAD will wrap around the federal effort by paying the difference between the 5 or 10 percent coinsurance on each claim and the $5 copayment required by PAAD.

But none of this will be easy. Mason's department recently sent a three-sentence letter to PAAD enrollees telling them to, essentially, do nothing – to not sign up for a Medicare card until the state had had a chance to sift through the Medicare-approved cards and could provide advice on the best one.

The department was immediately flooded with calls from enrollees asking such questions as whether they should stop renewing their enrollment in the PAAD program.

"You're dealing with a population, many of whom have cognitive impairment," Mason said. "We had 1,200 calls in response to that letter in two days. . . .We're very concerned about the confusion that this is going to engender."

DOWN EAST

Maine wants to make sure that it captures all of the available federal funds. Under Maine's Rx Plus card program, low-income enrollees are able to get Medicaid-like discounts on drugs that are on the preferred drug list.

Maine Sen. Peter Mills estimates that 5,500 of the 40,000 people in the state's drug program will be eligible for the federal benefit, which should save the state about $3 million a year. To capture those savings, the state recently passed a law requiring that its citizens spend down their federal benefit before tapping into the state program.

"Unfortunately, the existence of two overlapping subsidy systems will be difficult to administer and confusing to vulnerable beneficiaries," Mills said in a statement. "It would have been better if states. . .had simply been permitted to do their job. Maine has a wealth of data concerning the drug needs of this population and is ideally prepared to issue a composite card with a blended benefit. Unfortunately, the law does not permit states to enter the game."

Elsewhere, state legislators and officials are working overtime to modify or adjust their pharmaceutical assistance programs to the Medicare benefit. As of late March, at least 13 state legislatures had filed measures to aimed at implementing the Medicare card. (For more on state legislative activity, see www.ncsl.org)

Wyoming enacted a law similar to Maine's. It requires that individuals enrolled in its drug assistance program use the Medicare subsidy card as a "condition of participation" in the state drug program.

In Vermont, a bill would amend the existing state drug assistance program by using state funds to pay certain costs not covered by the federal drug benefit. Illinois is considering legislation that would direct the state to develop a new supplemental coverage program for beneficiaries, should its current 1115 pharmacy plus waiver program cease to exist.

Missouri is among the states looking ahead to 2006. A measure expected to pass there would direct the state to subsidize the notorious "donut hole" that will exist under Part D.

Under the law, beneficiaries will receive drug coverage until they have spent $2,250 on drugs in a year. They will then pay 100 percent of their drug costs, until they reach $3,600 in out-of-pocket spending, after which Medicare will pay about 95 percent of their drug costs. *CK*

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TRACKING *TRENDS*

From NCSL's HEALTH POLICY TRACKING SERVICE

State Laws Hamper Screening for Substance Abuse

The leading cause of death for people addicted to drugs and/or alcohol is injury and reinjury, not conditions like cirrhosis or pancreatitis. Perhaps the most promising way to identify substance abusers, and to increase the number of patients who get into treatment, is to screen those who show up in emergency departments (EDs) and trauma centers with injuries related to alcohol or drugs.

However, most trauma centers treat the injuries and ignore any underlying substance abuse problem. That's because, in most states, if an ED or trauma physician screens a patient for substance abuse, and the patient screens positive, the insurance company can deny payment for the medical bill.

Part of the problem is the Uniform Accident and Sickness Policy Provision Law (UPPL), a 1947 model law from the National Association of Insurance Commissioners that has been adopted by well over half of the states. The UPPL states that health insurers shall not be liable for any loss incurred because the insured was intoxicated or under the influence of any narcotic unless administered on the advice of the physician. The UPPL, wich was unveiled before addiction treatment centers were widely available, was supposed to decrease insurance costs, but it hasn't worked that way. Instead, physicians simply refuse to screen, and the insurer pays the medical bill. The law merely sweeps the problem of substance abuse under the rug.

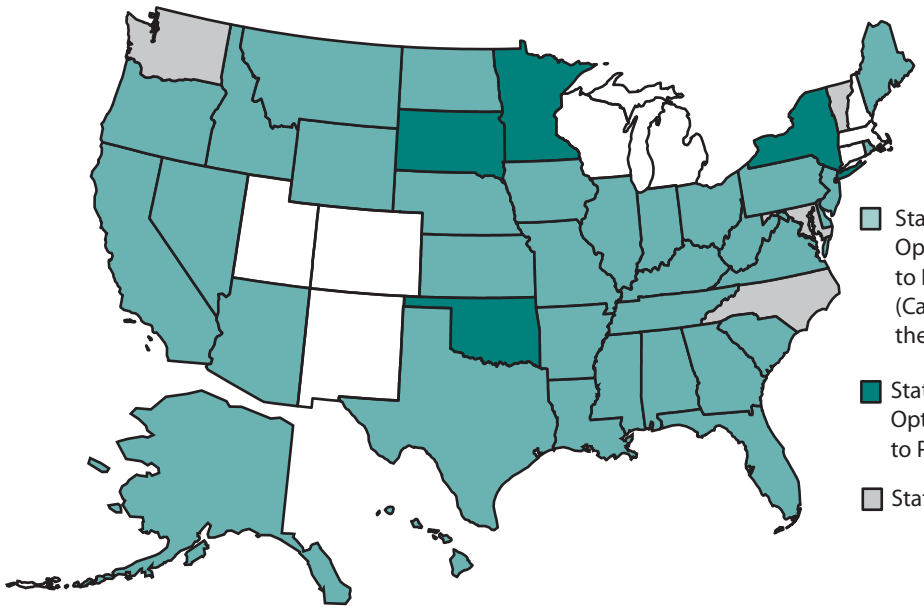
The American Medical Association recently called on states to repeal laws that inhibit screening for substance abuse. According to data presented to the AMA, more than 40 percent of patients treated in EDs are under the influence of alcohol or some other drug. But less than 15 percent of patients are screened or referred to counseling.

Surveys demonstrate that trauma centers are willing to test for substance abuse, and trauma clinicians support screening. But implementation would require removal of the severe financial penalties to trauma centers and to patients that the UPPL represents. ✦*AC*

This Trends is based in part on information provided to HPTS by Larry M. Gentilello, M.D., American Association for the Surgery of Trauma, and C. James Carrico, M.D., University of Texas Southwestern Medical Center at Dallas.

For more information on this topic call (703) 531-1213 or e-mail info@hpts.org

STATE UPPL LAWS



States with Laws that Give Insurers the Option to Deny Medical Reimbursements to Patients Under the Influence of Alcohol (California and Virginia have bills to repeal these laws)

States with Laws that Give Insurers the Option to Deny Medical Reimbursements to Patients Under the Influence of Narcotics

States that have Repealed such Laws

FOR YOUR *INFORMATION*

Just the Facts, Ma'am: Defining the Uninsured

A new book applies scientifically rigorous methodology to many long-held assumption about the uninsured -- and finds those assumptions lacking.

For example, many policymakers assume that a lack of insurance is inevitably linked to poor health. But the authors of *Health Policy and the Uninsured*, released in February 2004 by the Urban Institute, looked at hundreds of studies and concluded that there are no causative links between a lack of insurance and poor health.

The vast majority of studies suggest a positive correlation between health insurance and improved health outcomes. Looking north to Canada, for example, one study found that infant mortality decreased by 4 percent and low-birth weight dropped by 1.3 percent following the enactment of the national health insurance plan. And, results from an HIV cost and utilization study indicated that insurance status lowered the probability of dying within six months by 71 percent.

But the results of those studies are difficult to summarize because of the observational or quasi-experimental nature of the study designs, the authors say. Very few of the studies were rigorously controlled and very few illustrated the specific contribution of health insurance to health status.

Data from the only randomized experiment on this issue – the gold standard of research – suggest that health insurance coverage does reduce mortality, particularly for persons with high blood pressure, and it improves the health status of people with poor vision.

Funded by the Robert Wood Johnson Foundation, the book's six chapters address the *who*, *why* and *what* of lack of health insurance coverage.

Who is a troublesome question, the book notes. It's frequently stated that 44 million Americans (about 17 percent of the non-elderly population) were without health insurance in 2002. But the authors point out that varied research methodologies influence the count of the nation's uninsured population. For example, many of the surveys used to count the uninsured do not collect direct information about them. Instead, the surveys base data on the absence of positive responses to questions about different types of coverage – which may over-inflate the number of uninsured.

In 1999, various researchers used six different surveys to count the uninsured. The difference between the largest and smallest estimates: a whopping 7 million.

The chapter on *why* notes that the three main reasons for lack of insurance are: 1) healthy people decline coverage because they are unwilling to pay the premiums; 2) people want insurance but cannot get it because of insurance underwriting practices or "labor market rigidities"; and, 3) people want an insurance product that is available, but they cannot afford it.

According to one study reviewed by the authors, 99 percent of employers with 1,000 or more workers offered health insurance (compared to only 39 percent of institutions with 10 employees or less). Eighty percent of employees who were offered health insurance opted to accept coverage.

Participation in employer-sponsored health insurance has declined in recent years among full-time workers, especially among those who are less educated. Of workers declining insurance, 36 percent remain uninsured, while the remainder obtain coverage elsewhere. Data show that as the out-of-pocket price of health insurance grows relative to wages, more workers opt not to take up coverage.

A small number of employees decline health insurance even when their out-of-pocket costs are zero. Researchers suggest that their decisions are based on the fact that co-insurance and deductible requirements are more onerous than accessing charity and uncompensated care.

Looking at vulnerable populations, Hispanics and recent immigrants are most likely to not have health insurance coverage. Hispanics represent one-third of uninsured adults and 20 percent of uninsured kids. Young men and adults in the South between the ages of 17 and 64 are less likely to have insurance than comparable groups in other regions.

To obtain a copy of the book, visit http://www.urban.org or call (877) 847-7377

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